STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	C 07/16/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS On July 2, 2008 at approximately 12:21 PM the State Agency (SA) was notified via facsimile of an Unusual Incident Report (UIR) from the facility that revealed on June 30, 2008, the Incident Management Coordinator (IMC) was informed that Active Treatment Specialists (ATS) #1 witnessed ATS #2 "inappropriatly playing" with Client #1 by playfully hitting him with a placemat on June 23, 2008. The SA conducted an on-site investigation on July 10, 2008 to verify compliance with the basic standards of practice and federal requirements in Governing Body and Client Protection. The investigation determined that ATS #2 was placed on administrative leave on July 1, 2008. The investigation also determined that the Qualified Mental Retardation Professional (QMRP) was placed on administrative leave on July 1, 2008. The results of the investigation were based on interviews with ATS and administrative staff. Also the findings were based on the review of the client's medical record, and the facility's administrative records; including incident reports.	W 000	Received 8/20/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interview and record review, the governing body exercised general policy and operating direction over the facility, except in the following areas:	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE ADRS (X6) DATE 8/20/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 The findings include: 1.Cross refer to W153. The governing body failed to provide sufficient administrative oversight to ensure the implementation of its incident management policy involving reporting all allegations of abuse immediately to the administrator. 2.Cross refer to W267. The governing body failed to provide sufficient administrative oversight to ensure the implementation of its written policies and procedures for the management of conduct between staff and clients.	W 104	— **W104** **This standard will be met as Evidenced by:** Review of record indicates that The facility currently has written policies and procedures regarding abuse/neglect and mistreatment. A team efforts has been utilized by the senior management (Director of Residential Services, Director of nursing, RN and Training Department) to retrain all in the area of abuse/neglect, incident reporting, documentation and programming. The facility will ensure that all incidents are reported to pertinent agency/management in accordance with district law and that confirmation report is file on client record/incident report book. The facility management/Training department will continue to train staff on an on-going basis and will ensure all incident of abuse/neglect or mistreatment are thoroughly investigated in accordance with standard. Any employee that fails to comply with this standard as set forth will be subject to disciplinary action. Cross reference W153 Cross reference W267	7/10/2008
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's staff failed to implement it's incident management protocol for one of one client in the investigation (Client #1) and failed to implement its written policies and procedures for the management of conduct between staff and clients for one of one client in the investigation. (Client #1) The findings include: 1.Cross refer to W153. The facility staff failed to ensure its incident management policy was implemented involving reporting all allegations of abuse immediately to the administrator and government agencies.	W 149		

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W 149	Continued From page 2 2.Cross refer to W267. The facility staff failed to ensure its ensure its written policies and procedures for the management of conduct between staff and clients were implemented by all staff.	W 149	**W149** **This Standard will be met as Evidenced by:** Review of record noted that the facility has a written policies and procedures addressing abuse, neglect, mistreatment, client rights and sensitivity. All staff was previously trained on the policies as established. In addition, additional training has been provided to reinforce this standard. Facility management will continue to provide on-going training to staff in the areas mentioned above and in accordance with policies and procedures. Cross Reference W267	7/18//2008
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure that all allegations of abuse are reported immediately to facility's administrator and government agencies as required by DC Regulation (22 DCMR Chapter 35 Section 3519.10). The finding includes: Interview with the FC on July 10, 2008 at approximately 3:15PM revealed that on June 24, 2008 the Qualified Mental Retardation Professional (QMRP) informed her that the Department of Disability Services (DDS) had informed him of an anonymous allegation of abuse at the facility on June 23, 2008. The FC stated that she was informed by the QMRP that he was during an internal investigation. The FC revealed that on June 26, 2008, ATS #1 informed her that she witnessed ATS #2 "inappropriately playing" with Client #1 by playfully hitting him with	W 153		

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W 153	Continued From page 3 a cotton placemat on June 23, 2008. The FC revealed that she immediately informed the QMRP who informed her that he would notify the administrators and other officials. Interview with the IMC on July 14, 2008 at approximately 10:00 AM revealed that while reviewing the MRDDA Consumer Information System(MCIS) on June 30, 2008, it was discovered that there were several rejected incidents of allegations of abuse at the facility. The IMC telephoned the QMRP on that same day in order to ascertain what he knew about the rejected incidents of allegations of abuse at the facility, however he did not respond. On July 1, 2008, the IMC did an on-site visit to the facility and was informed by the QMRP that DDS had informed him on either June 24 or June 25, 2008 of an allegation of abuse that occurred at the facility on June 23, 2008. The IMC stated that the QMRP informed her that he was during an internal investigation, however he had not informed the facility administrator of the allegation of abuse. Interview with the QMRP on July 23, 2008 at approximately 10:15AM revealed that on June 24, 2008, DDS had informed him of an anonymous allegation of abuse involving unknown clients at the facility on June 23, 2008. The QMRP revealed that on June 26, 2008, the FC informed him that ATS #1 witnessed ATS #2 "inappropriately playing" with Client #1 by playfully hitting him with a cotton placemat on June 23, 2008. The QMRP revealed that he had not informed the facility administrator. Further interview with the QMRP revealed that he had not informed the facility administrator of the allegation of abuse that had been reported by DDS or the Department of	W 153	W153 This Standard will be met as Evidenced by: Review of record noted that the QMRP received training on policies and procedures as related to incident reporting/incident investigation as part of the orientation to the agency and including DDS incident management training. The QMRP no longer work for the agency. All staff has been re-trained on abuse, neglect and mistreatment. In future, the Training department will complete a periodic audit/monitoring of facility training book to ensure that all employee continue to receive on-going training on incident reporting, abuse/neglect, client right/sensitivity in compliance with the policy and procedure.	7/25/08

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W 153	Continued From page 4 Health (DOH). Review of the Incident Management Policy dated July 1, 2003 on July 14, 2008 at approximately 4:40 PM revealed that "any person who witnesses, discovers or is informed of a Serious Reportable Incident as defined by this policy, must immediately verbally report the incident to the immediate supervisor/manager on duty. The facility staff on duty will accept reports of Serious Reportable Incidents, on a 24 hour, 7 days a week basis." There was no evidence that the facility's QMRP immediately reported an allegation of abuse to the facility's administrator and DOH.	W 153		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate, and coordinate the health and safety needs for eight of eight clients in the facility. (Client #1, Client #2, Client #3, Client #4, Client #5, Client #6, Client #7 and Client #8) The finding includes: Cross refer to W153. The QMRP failed to ensure that all allegations of abuse were reported immediately to the administrator and government agencies.	W 159	**W159** **This Standard will be met as evidenced by:** 1. Cross reference W153.	7/25/2008

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W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently. The findings include: 1. Cross Refer to W153. The facility failed to ensure that the staff had received effective training on implementing the facility's incident management policy related to reporting allegations of abuse immediately to facility's administrator and government agencies. 2. Cross Refer to W267. The facility staff failed to ensure that the staff received effective training in implementing the written policies and procedures for the management of conduct between staff and clients for Client #1.	W 189	W189 This standard will be met as evidenced by: Cross Reference W153 Cross Reference W267	7/10/2008
W 267	483.450(a)(1) CONDUCT TOWARD CLIENT The facility must develop and implement written policies and procedures for the management of conduct between staff and clients. This STANDARD is not met as evidenced by: Based on interview, the facility failed to ensure that written policies and procedures for the management of conduct between staff and clients	W 267		

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W 267	Continued From page 6 were implemented by all staff, for one of the one client in the investigation. (Client #1) The finding includes: On July 2, 2008 at approximately 12:21 PM the State Agency (SA) was notified via facsimile of an Unusual Incident Report (UIR) from the facility that revealed that on June 30, 2008, the Incident Management Coordinator (IMC) was informed that Active Treatment Specialists (ATS) #1 witnessed ATS #2 "inappropriatly playing" with Client #1 by playfully hitting him with a cotton placemat on June 23, 2008. Interview with ATS #1 on July 10, 2008 at approximately 2:45PM revealed that she witnessed ATS #2, "inappropriately playing" with Client #1 by playfully hitting him with a cotton placemat on June 23, 2008. Interview with the ATS #2 on July 14, 2008 at approximately 9:10 AM revealed that on one evening that she was asked to work(date unknow), Client #1 "was making hand gestures to say that he [Client #1] was going to hit me in the eye, I told him [Client #1] that if he didn't stop he was going to get a beating and he started laughing out loud and rolling his eyes at me and I stated rolling my eyes, and we both started laughing." Further interview revealed that Client #1 started making hand gestures again and ATS #2 stated that she then rolled up a cotton placemat and "tapped" Client #1 on the legs and they both laughed. Interview with the ATS #3 on July 14, 2008 at approximately 9:40 AM revealed that on one evening that ATS #2 worked with him (date	W 267		

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W 267	Continued From page 7 unknown), he observed ATS #2 " waving her hand toward Client #1, but was not sure if ATS #2 made contact with Client #1's body. Further interview revealed that ATS #3 did not report the above as an incident because " I thought that ATS #2 and Client #1 were playing". Review of the written policies and procedures to protect clients' dignity and rights on July 21, 2008 at approximately 5:30PM revealed that " services and supports will include communications that are courteous, respectful of the dignity of the individual and facilitate the person's understanding of what is being communicated." There was no evidence that written policies and procedures for the management of conduct between staff and clients were implemented.	W 267	W267 This Standard will be met as Evidenced by: Disciplinary action has been given to ATS #2 for failure to follow policies and procedures as written. All staff has been retrained on client rights, abuse/neglect and client sensitivity. The facility management will continue an on-going training of conduct and sensitivity to individuals in accordance with written policies and procedures. Evidence of such training will be file in the training book.	7/25/2008

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I 000	INITIAL COMMENTS On July 2, 2008 at approximately 12:21 PM the State Agency (SA) was notified via facsimile of an Unusual Incident Report (UIR) from the facility that revealed that on June 30, 2008, the Incident Management Coordinator (IMC) was informed that Active Treatment Specialists (ATS) #1 witnessed ATS #2 "inappropriatly playing" with Resident #1 by playfully hitting him with a cotton placemat on June 23, 2008. The SA conducted an on-site investigation on July 10, 2008 to verify compliance with the basic standards of practice and federal requirements in Governing Body and Client Protection. The investigation determined that ATS #2 was placed on administrative leave on July 1, 2008. The investigation also determined that the Qualified Mental Retardation Professional (QMRP) was placed on administrative leave on July 1, 2008. The results of the investigation were based on interviews with ATS and administrative staff. Also the findings were based on the review of the resident's medical record, and the facility's administrative records; including incident reports.	I 000	Received 8/20/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.	I 379		

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE AIRS (X6) DATE 8/19/08

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I 379	Continued From page 1 This Statute is not met as evidenced by: GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. The finding includes: Interview with the FC on July 10, 2008 at approximately 3:15PM revealed that on June 24, 2008 the Qualified Mental Retardation Professional (QMRP) informed her that the Department of Disability Services (DDS) had informed him of an anonymous allegation of abuse at the facility on June 23, 2008. The FC stated that she was informed by the QMRP that he was during an internal investigation. The FC revealed that on June 26, 2008, ATS #1 informed her that she witnessed ATS #2 "inappropriately playing" with Resident #1 by playfully hitting him with a cotton placemat on June 23, 2008. The FC revealed that she immediately informed the QMRP who informed her that he would notify the administrators and other officials. Interview with the IMC on July 14, 2008 at approximately 10:00 AM revealed that while reviewing the MRDDA Consumer Information System(MCIS) on June 30, 2008, it was discovered that there were several rejected incidents of allegations of abuse at the facility. The IMC telephoned the QMRP on that same day in order to ascertain what he knew about the	I 379		

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I 379	Continued From page 2 rejected incidents of allegations of abuse at the facility, however he did not respond. On July 1, 2008, the IMC did an on-site visit to the facility and was informed by the QMRP that the DDS informed him on either June 24 or June 25, 2008 of an allegation of abuse that occurred at the facility on June 23, 2008. The IMC stated that the QMRP informed her that he was during an internal investigation, however he had not informed the facility administrator of the allegation of abuse. Interview with the QMRP on July 23, 2008 at approximately 10:15AM revealed that on June 24, 2008, DDS had informed him of an anonymous allegation of abuse involving unknown clients at the facility on June 23, 2008. The QMRP revealed that on June 26, 2008, the FC informed him that ATS #1 witnessed ATS #2 "inappropriately playing" with Resident #1 by playfully hitting him with a cotton placemat on June 23, 2008. The QMRP revealed that he had not informed the facility administrator. Further interview with the QMRP revealed that he had not informed the facility administrator of the allegation of abuse that had been reported by DDS or the Department of Health (DOH). Review of the Incident Management Policy dated July 1, 2003 on July 14, 2008 at approximately 4:40 PM revealed that "any person who witnesses, discovers or is informed of a Serious Reportable Incident as defined by this policy, must immediately verbally report the incident to the immediate supervisor/manager on duty. The facility staff on duty will accept reports of Serious Reportable Incidents, on a 24 hour, 7 days a week basis." There was no evidence that the facility's QMRP	I 379		

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I 379	Continued From page 3 immediately reported an allegation of abuse to the facility's administrator and government agencies.	I 379	3519.10 This Statue will be met as evidenced by: Reference W104, W149, W153 And W267	7/10/2008